STRATEGY REF NO SABP 001

NAME OF APPROVED DOCUMENT:	Risk Management Strategy
PURPOSE OF APPROVED DOCUMENT:	To define the Trust's approach to managing risk and the identification of roles and responsibilities. This document also outlines the management of our security risks and our approach to managing risks related to the PREVENT Agenda.
WHO NEEDS TO KNOW ABOUT IT?	All staff who have responsibility for managing risks.
DATE APPROVED:	November 2014
VERSION NUMBER:	4.0
APPROVING COMMITTEE:	Executive Board
DATE OF IMPLEMENTATION:	April 2015
DATE OF FORMAL REVIEW:	November 2019
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RESPONSIBLE DIRECTOR:	Director of Quality
DISTRIBUTION:	All Directorates clinical and managerial staff.

Contents

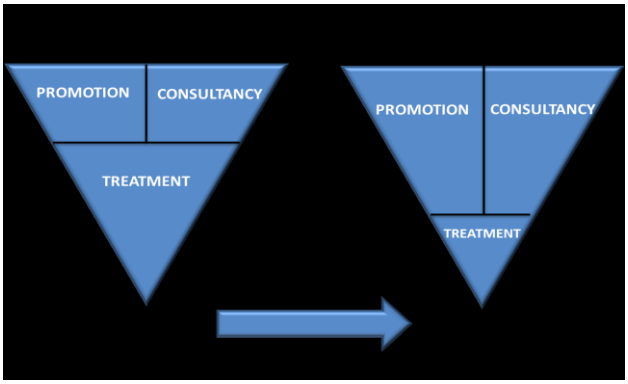
RISK MANAGEMENT STRATEGY

1. Introduction

The management of risk is everyone's responsibility. Good risk management underpins quality of patient care, be it through direct clinical care or indirectly from support services. Our ambition is to be better than the best. We want people who use our services and their families to feel and be safe in our care due to our robust risk management arrangements. We want staff to be proud and feel safe to work in our Trust and feel confident and support in their management of risk.

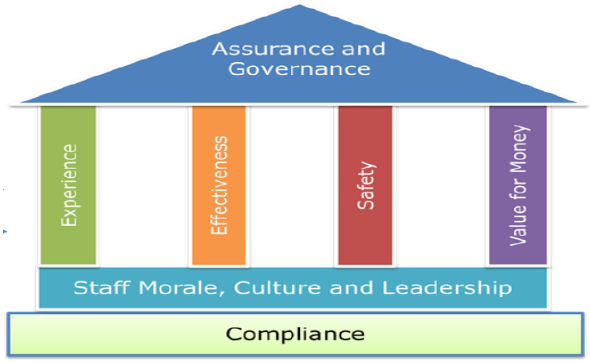
We as an employer are required by law to eliminate the risk where possible. If this is not possible then as far as is reasonably practicable the risks should be reduced by the use of control measures. This applies equally to all tasks from undertaking a domestic role to delivering therapeutic interventions with people who use our services. The level of risk varies, but the requirement to manage the risks remains the same.

This strategy sets the direction of travel for Surrey & Borders Partnership NHS Foundation Trust's management of strategic and operational risks. It will also include our approach to managing risks related to the embedding of Security arrangements and the management of those related to the PREVENT Agenda, which is an element of CONTEST, the government's counter-terrorism strategy. PREVENT aims to stop people becoming terrorists or supporting terrorism.

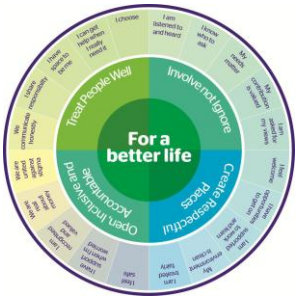


The strategy is an enabler that will promote managed positive risk taking and minimise the risk of adverse outcomes to people using our services, staff, the organisation, and to third parties by supporting the Clinical Strategy which focuses on delivering a more preventative model going forward and the establishment of robust structures, systems and processes that will make our processes more reliable and safer.

The strategy will facilitate the prompt identification of risks through the pillars of our Quality House as set out in our Quality Plan and will ensure a consistent process of monitoring and escalation through the risk register any deviation from our Quality or Forward Plans that may pose an operational, strategic, financial or reputational risk to the Trust.



Our vision and values will enable this strategy to create a culture of awareness and responsibility for the assessment, management and mitigation of risk at all levels in the organisation, whether through individual practice or through management arrangements. This will also help in mitigating the risks associated with delivering on our Clinical Strategic Priorities and Objectives:



- One person, one plan: Connecting mind, body and social context
- Promoting wellbeing through prevention, early detection and early intervention
- Building services around people and communities
- Supporting people to recover
- Consulting and partnering for success
- Safeguarding and improving the quality of clinical and care services.

2. Aims

The purpose of this document is to provide guidance to all staff on the management of strategic, security and operational risks within the organisation. It aims to:

- Set out respective responsibilities for strategic and operational risk management for the

Board and staff throughout the organisation;

- Describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of critical success factors;
- Ensure there are robust security processes in place to protection staff, people who use our services and visitors;
- Ensure there are sufficient risk management processes to protect personal belongings of staff, patients and visitors;
- Protect Trust property;
- Ensure there are sufficient risk management processes to mitigate risks related to the management of violence and aggression;
- Ensure the reporting of all incidents, including near misses and the availability of information regarding crime and on reducing crime.

3. Roles & Responsibilities:

- The **Chief Executive** has overall accountability for risk management and has delegated lead responsibility to the Director of Quality (Deputy CEO) to co-ordinate the risk management programme.

- All other **Directors** have responsibility for managing risks within their respective areas of responsibility. They have overall responsibility for the escalation of high level and extreme risk from their respective areas to the Trust Risk Register for discussion at the Executive Board & Trust Board.

- The **Director of Risk & Safety** has delegated responsibility to coordinate and manage the implementation of the Risk Strategy and to work as part of the Quality Directorate to identify early warning signs that may pose a risk to services delivery and support in identifying and delivering processes to mitigate identified risks with support from the

Risk team.

- All **Managers** have authority within the remit of their roles to make decisions to mitigate any adverse significant risks. Managers will manage all low and medium risks in the local risk registers on Datix. Managers will ensure that risks that regarded as high or extreme risks are shared with respective Directors for escalation onto the Trust Risk Register.

- All **Staff** have the responsibility and authority within the remit of their roles to make decisions to assess risk in their local areas. Where a risk has been identified, then they have the responsibility to take immediate action where necessary to reduce the risk of harm to people, escalate this to their respective manager for further analysis, action and escalation where required. (Refer to appendix A for further detail on authority for staff)

4. Background

We recognises that risk management is an integrated part of the management process, enabling managers to focus on the achievement of key objectives, and we as a Trust that is aspiring to be the best in what we do, will continue to work towards risk management being an integral part of the culture of the organisation. This includes disseminating the message that all staff have a responsibility to identify and minimise unacceptable risks and providing staff with the tools to assist them in undertaking this responsibility.

We endeavour to create an open, just and fair culture that encourages all staff and contractors to report risks, hazards, near misses and incidents. In addition, people who use our services and carers are encouraged to report concerns or any risk related issues to healthcare professionals, the Complaints and Patient Advice and Liaison Service (PALS) Team and Legal Services Team so that lessons are learned and disseminated across the organisation.

Risk can be described as the uncertainty of outcome (whether positive opportunity or negative threat). It is the combination of the chance of an event and its consequences. Risks are identified and assessed on a continuous and systematic basis through the regular review of risk register reports and other information sources at team and committee meetings. Anyone can report a risk and take responsibility for the collection of information about the risks of a particular service and update the risk register accordingly.

5. Security Risk Management Arrangements

All employees of Surrey and Borders Partnership NHS Foundation Trust have a responsibility to ensure security arrangements remain robust to protect staff, people who use services and NHS property. We remain committed to the creation of a culture amongst our staff, people using our services and the public where the responsibility for security is accepted by all and the actions of the minority who breach security are not tolerated. All security risks to will be managed in line with this Risk Management Strategy and solutions identified to mitigate the risks to an acceptable level.

Security Management Director (SMD): The Director of Quality (Deputy CEO) is the Trust SMD. *There is responsibility of the Chair/Chief Executive of all NHS health bodies to designate an Executive Director or Officer to the role of SMD. The SMD must be a voting member of the trust board and ensure that adequate security management provision is made in their NHS health body.*

We will comply with all current legislation and work with the NHS Security Management Service (NHS Protect), and will aim to identify and manage security risks by undertaking the following:

- Adopting "Zero Tolerance approach" to discrimination / Abuse / Violent Behavior
- Support Staff if/ when they are involved in a violent or aggressive assault
- Support Staff to seek redress if they are involved in a violent or aggressive assault
- Enhance liaisons with the Police
- Prevent and Deter crime in the Trust to take away the opportunity for crime to occur or to

re-occur and discourage those individuals who may be tempted to commit crime

- Increase the use of sanctions & hold to account those individuals who assault NHS Staff who are aware of their actions and those who commit a crime
- Local agreement of Memorandum of association with Surrey and Hampshire Police forces

6. Prevent Agenda Risk Management Arrangements

The Prevent strategy responds to the ideological challenge we face from terrorism and aspects of extremism, and the threat we face from those who promote these views. It provides practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support.

The strategy covers all forms of terrorism, including far right extremism and some aspects of non-violent extremism. However, work is prioritised according to the risks. It works with a wide range of sectors (including education, criminal justice, faith, charities, online and health) where there are risks of radicalisation that we need to deal with. All risks to the Trust posed by extremism will be escalated to the Trust Risk Register and managed in accordance with the Risk Management Strategy.

The Trust Prevent Lead will escalate concerns through the Director of Risk & Safety, the Quality Management Board and the Executive Board as required.

SABP Contribution and Participation

In partnership with the South East Counter Terrorism Unit we will:

- maintain a Prevent lead for point of contact within the Trust
- ensure Prevent Awareness training is available to all staff
- contribute and participate in all local Prevent activities including raising Prevent awareness
- ensure that Prevent materials are available on are intranet for staff to access
- include Prevent materials on our public facing website
- incorporate Prevent into our safeguarding processes
- participate in Channel meetings as required
- include Prevent referrals /reporting in out datix reporting system

7. Risk Classification List

Business Risks

Communications Contracts Finance Information Management and Technology Marketing Nursing Strategy Procurement and Supplies Projects Quality and Performance Reputation Workforce

Compliance Risks

Clinical, MCA/DOLS, Environment, Equality and Human Rights, Fire Safety, Health & Safety Essential Standards , Information Governance, Mental Capacity Act, Mental Health Act .

We will identify risks through a range of information sources. Managers shall identify all types of risk that may impact upon the delivery of services for which they are responsible. Once these risk types have been identified managers shall undertake their risk assessments and record the information on Datix for escalation onto the Risk Register.

8. Management of risks locally & escalation onto the High level risk register

Each Division/ Directorate will be responsible for maintaining the operational risks within their Division/ Directorate and service. The Director of Risk & Safety will review all risks logged on Datix and moderate in accordance to the risk matrix whether a risk requires escalation to the High Level Risk Register.

9. Risk Management Structure

Our Risk Management Framework consists of the following interrelated components: Risk Management

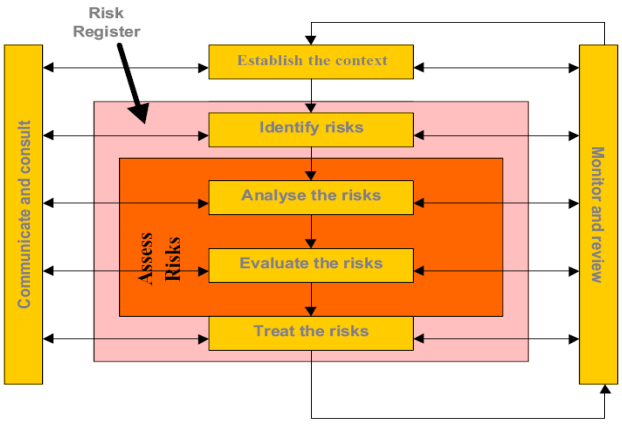


Figure 1. AS/NZS 4360,1999

Structure (including roles and responsibilities), Risk identification and assessment, Risk treatment/response, Monitoring and Risk Control Review, Information, Communication and Training. All the components are linked and serve as criteria for determining the effectiveness of the risk management system.

The main elements of the risk management process are as shown in Figure 1 above (Australian / New Zealand Standards – AS / NZS 4360:1999).

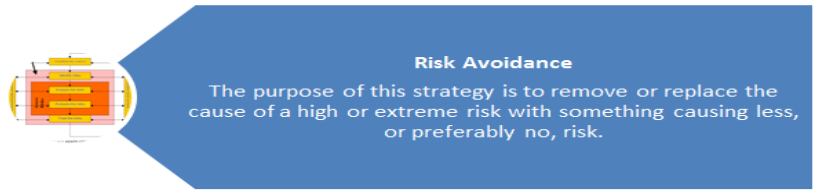
Stages	Action
Establish the Context	Establish the strategic, organisational and risk management context. (what does this risk relate to eg Reputational damage, safety etc
Identify the Risks	Identify what, why and how things can arise as the basis for further analysis. The identification process takes many forms and embraces both a proactive approach and one that reviews issues retrospectively.
Analyse the Risks	Determine the existing controls and analyse risks in terms of consequence and likelihood in the context of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. Consequence and likelihood may be combined to produce an estimated level of risk.
Evaluate the Risks	The purpose of risk evaluation is to quantify the impact that the unmanaged/uncontrolled risks may have on the Trust. This quantification or assessment may range from insignificant to catastrophic and will subsequently enable the organisation to compile a hierarchy or prioritisation of risks. This, in turn, enables control actions to be taken by allocating resources - time, money, people, effort - to commensurate risk control techniques designed to eradicate or minimise the assessed risks.
Control (Treat) the Risks	The Trust agrees that not all risks can be avoided or eliminated. The Trust Board will monitor low-priority risks and accept those significant organisational risks that cannot be reduced or eliminated, providing all relevant information is documented on the Trust's Risk Register and is subject to regular review. The degree of risk acceptance cannot be based on a risk grading score alone. Directors and delegated deputies as appropriate, supported by the Director of Risk & Safety , are responsible for managing all risks as follows: • Risk score 1-3 (green), managed, within the service area, by the local manager • Risk score 4-6 (yellow), managed within the service area, by the local manager, but reported to the Senior Manager, who will monitor actions. • Risk score 8-12 (amber), these actions will be prioritised by the Senior and Divisions, and reported to the appropriate Director.

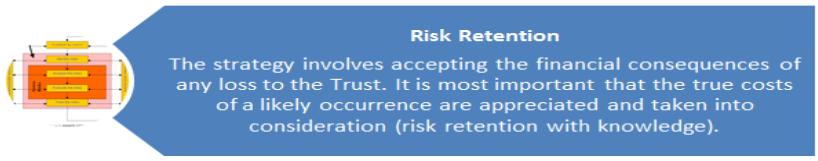
10. Risk Control Strategies

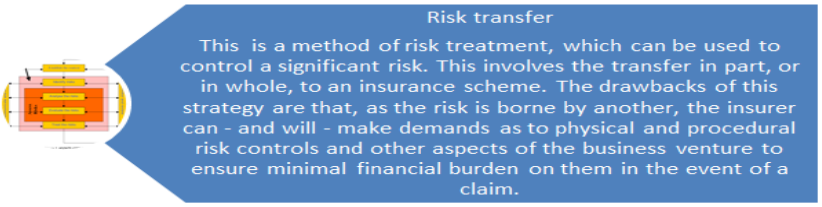
Effective risk management is based on the answers to three considerations:

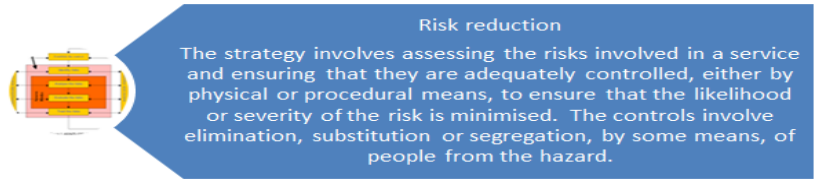
- What is the organisation's current position (where are we now?).
- What is the necessary, desired or required position (where do we want to be?).
- What is necessary to achieve the end result from the current position (how do we get there?).

By viewing the risks to an organisation in this way, it is possible to more easily prioritise them during the evaluation phase.









There are four main risk control strategies in risk management. Each has benefits and the choice between them can usually only be made on a case-by-case basis. It is important, however, that the choice of strategy is made from a position of full knowledge (where possible) as it is all too easy to select a strategy for apparently good reasons, only for it to fail because all the factors and implications were not appreciated. These strategies are set out in the following sections.

11. Risk Register

The Risk Register is an essential tool in aiding the Trust to identify and manage its 'risk portfolio' and enables all risks, which affect the Trust, to be identified, including:

- Clinical (although not at the individual level) and non-clinical risks.
- Strategic risks.
- Financial risks.
- Operational risks.
- The risk priorities of partners and how their behaviour may affect the risks to the Trust.

It will also enable risks to be:

- Categorised.
- Rated and recorded.
- Assessed against each other and on a Trust wide and service basis to facilitate organisational decision making.
- Inform the development of risk management action plans and policy and capture data from a variety of sources including:

Incident reports, Controls assurance action plans, Consultation and observation. Hazardous substances, Surveys, inspections, assessments and audit. Contingency plans and disaster recovery, Adverse incidents, Medical records, Fire Audits, Claims and complaints, Task / process analysis, Equipment purchase / modification Preventative maintenance issues, Critical equipment, Risk assessments, Financial information and risks, Contractual and commissioning sources, Project management.
Provide evidence for external assessing organisations, such as:
NHS Litigation Authority, The Care Quality Commission, Commissioners, Health and Safety Executive (HSE), etc.

12. Risk Mitigation Action plans

These will be developed whenever the level of risk needs to be further reduced. All risk action are logged on Datix and these are monitored regularly through existing governance processes such as local Quality Assurance Groups and regular senior management oversight

13. Risk Management & Escalation

Risks are identified and escalated through different levels of management to the Board, using a standard linked register. This empowers risk management decision making to occur as near as practicable to the risk source. In addition, significant risks and those that cannot be treated can be passed upwards to the appropriate level.

Risk Grading 15 – 25 (Red), high probability that a hazard may cause death, major permanent injury, major financial loss or lead to a case for litigation. Grading 8 -12 (Orange), moderate probability that a hazard may cause semi-permanent injury / serious damage, high financial loss or lead to a case for complaint or litigation.

- The manager must STOP activity and, if necessary, make the situation safe.
- Immediate action must be taken to either eliminate or adequately control the risk before any further activity is undertaken.
- Report immediately to the appropriate Senior Manager and Director.
- Action plans will be developed whenever the level of risk needs to be further reduced.
- The Director of Risk and Safety, will have overall responsibility for the development and maintenance of the corporate risk register, which will record risks rated 15 or above.

- **The High Level risk register will be reviewed by the Trust Board; The Executive Board will review, at each of their meetings, those risks that may affect the quality of service delivered.**
- The Audit Committee will consider the corporate risk register, at each of their meetings, with a view to ascertaining if the process for capturing the risks and addressing them provides sufficient assurance to the Board.
- If the retained risk is graded as 15 or above, the risk will continue to be managed as a High Level (red) risk.
- If the retained risk remains within the 8 – 12 range, the risk management process continues as above.
- If the retained risk is reduced to within the 4 – 6 range, the risk management process continues as for yellow risks.
- If retained level of risk decreases below 4, the risk management process continues as for green risks.

Risk Grading 1 – 3, (Green), very low probability that a hazard may cause an injury / damage or low financial loss	• Report to Local Manager and together assess the severity of the risk / incident. • Undertake causal investigation at local level. • Local management teams: • Monitor trends associated with this grade of risk • identify where causal factors are generic to the service / area. • Take appropriate action to address any local system failures. • Any proactive assessment graded as very low can be considered as acceptable risk. • Risk / incident may be closed if sufficiently mitigated.
Risk Grading 4 – 6, (Yellow), low probability that a hazard may cause minor injury / damage, minor financial loss or lead to a case for complaint.	• Report to Local / Senior Manager and together assess the severity of the risk / incident. Undertake causal investigation at local level. • Local Management teams: • Monitor trends associated with this grade of risk / incident. • Identify where causal factors are generic to the service/area. • Take appropriate action or develop an action plan to address any local system failures. • review and monitor progress on risk mitigation in local governanace arrangments • Any proactive assessment graded as low should be kept under review. • Risk entered on local risk register and accepted / controlled at service/local level or referred to Director. • If the retained risk remains within the 4 – 6 range, local management teams continue as above • If retained level of risk decreases below 4, local management teams follow guidance for green risks.
Risk Grading 8 -12 (Orange), moderate probability that a hazard may cause semi-permanent injury / serious damage, high financial loss or lead to a case for complaint or litigation	• The Manager should : • Make the situation safe. • Review the effectiveness of existing control measures. • If adequate control cannot be implemented immediately, an action plan must be developed. • This should indicate: • How the risk will be reduced • Who will be responsible for implementation? • The timescale. • Report immediately to the appropriate manager. • All moderate risks must be: • Included on to Datix Risk • Notified to Director for acceptance / treatment / referral to Trust Board. • Risk action plans monitored and reviewed by the Directorate/ Division. • If the risk grading increases to 15 or above, the risk should be escalated to the High Level risk register and managed as for red risks (see next section). • If the retained risk remains within the 8 – 12 range, the risk management process continues as above. • If the retained risk is reduced to within the 4 – 6 range, the risk management process continues as for yellow risks. • If retained level of risk decreases below 4, the risk management process continues as for green risks.

14. Process for review of the organisation-wide risk register

The **Trust Board** receives verification on the Assurance Framework and systems of internal control on an annual basis through a programme of audit agreed through the Audit Committee. The Trust Board regularly receives and reviews the Trust High Level Risk Register.

The **Executive Board** meets monthly and reviews the Trust High Level Risk Register and has the responsibility of seeking assurance on the availability of adequate controls and actions to mitigate identified High level & Extreme risks.

The **Audit Committee** which is made up of Non-Executive Directors, Internal and External Audit have responsibility for monitoring the risk management system and for providing appropriate verification/assurance to the Chief Executive and Trust Board. Each year the Chief Executive Officer is required to sign a Statement of Internal Control [SIC] that confirms that the Trust has in place a comprehensive system for internal control of risks and that action has been taken to manage those risks.

This system for internal control is directly linked to the Trust's Framework for Assurance and Risk Management. The Assurance Framework consists of all key strategic risks and these are contained in the High Level Risk Register. Both the Assurance Framework is reviewed Annually by the Executive Board and Trust Board. The Assurance Framework is presented to the Audit Committee at least annually.

The **Quality Committee** meets quarterly and is the Board delegated risk committee; it is made up Directors, Associate Directors, Managers, carers, people who use the Trust's services. Figure 1 below shows organisational structure.

The **Quality Management Board** meets monthly and oversees the day to day management of activities including the identification of early warning signs that may warrant support to mitigate Risks to the delivery of core business at a high quality.

15. Committee with over-arching responsibility for risk

The **Quality committee** is the Trust Board delegated committee that has responsibility for Risk. The Committee is authorised by the Board to:-

- Monitor the quality of the Trust's services
- Provide assurance on the quality of our services; ensuring compliance with at least statutory minimum requirements e.g. Care Quality Commission, Monitor standards
- Ensure risks to the delivery of quality services are identified, prioritised and actions are being taken to mitigate them within the risk appetite of the Trust
- Oversee the delivery of continuous quality improvement in the experience of people who use services, carers and staff
- Ensure lessons are learned as a result of incidents and failings in the quality of experience
- Ensure progress on improving quality is communicated and celebrated to spread good practice

Its work supports the development of the Trust's Quality Account and progress on the delivery of its clinical quality priorities. The Quality Committee reports to the Trust Board of Directors. This report is provided by the Committee Chair following each Committee meeting.

The Quality Committee receives reports in accordance with its reporting calendar from the following Committees and Groups:-

- Quality Management Team (Operations Directorate)
- Mental Health Act Committee
- Policy Assurance Group
- Trust Scrutiny Panel
- Health and Safety Committee
- Information Governance Committee

In addition the Committee will receive regular reports which provide assurance on quality, risk and safety. For example, Deep Dive, safeguarding, clinical audit, surveys on the experiences of staff, people who use services and carers 'Your Views Matter'

The reports to the Committee will enable it to monitor the implementation of the following policies to ensure they are consistent with legislation, relevant standards and best practice:

- Recruitment (employment and professional and clinical registration checks)
- Induction
- Security
- Inoculation incidents
- Harassment and bullying
- Prevention and management of violence and aggression
- Stress
- Clinical supervision
- Complaints
- NICE implementation
- Care Programme Approach
- Incident management
- Information Governance
- Medicines management
- Records Management
- Physical healthcare
- Safeguarding Children
- Safeguarding Adults
- Security
- Moving and handling
- Slips, trips and falls
- AWOL
- Medical emergency and resuscitation
- Infection prevention and control
- Claims
- Policy on procedural documents
- Health and safety
- Fire safety
- Information Security

See Appendix D for Organisational structural chart and lines of reporting, including specialist groups

16. Process for assessing all types of risk

- The Trust's Risk Management Information System (DATIX) will be used to collate data and information about incidents, complaints, claims and risks and supply management at all levels with relevant information for managing operational risks and making

informed decisions relative to the Trust's objectives.

- Information systems implemented in the Trust are capable of communicating significant information both with internal and external parties, i.e. National Patient Safety Agency.
- All Trust managers will be responsible for updating the Datix to record risk information and monitor risks in their area of responsibility and be able to change the status and description of existing risks and input new risks and mitigation plans. Staff within each Division/ Directorate are responsible for maintaining the information on risk management and updating the risk database system and producing reports.

17. Process for ensuring a continual, systematic approach to all risk assessments

The main tool in risk management and ranking is the Risk Severity Table that allows assessors to classify their risks based upon the same principles.

Table 1 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk	
4 - 6	Moderate risk	
8 - 12	High risk	
15 - 25	Extreme risk	

18. Instructions for use

- Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
- Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
- Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
- Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)
- Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

19. Trusts Strategic objectives Management

The Trusts Strategic objectives and business plans are performance managed by the Executive Board. All Directors are responsible for identifying the risks associated with each project/objective and ensuring that adequate controls are in place to mitigate the risks and record the details on the High level risk register. Directors / Staff will be able to categorise the

risks against the Trust's objectives and Essential Standards

20. Operational risk register

Operational risks are those risks concerned with continuity of business services. These risks have a direct impact on day to day services and would include Health & Safety, Fire Safety, Infection Control, Security, (including Information Security, Estates/Project management, Quality of service, Standards of care and treatment, etc. Managers will undertake risk assessments of their service and record those assessments on the Trust's risk register. If these risks have a score of 8 or above they may be escalated onto the Trust High Level Risk Register, following review by the responsible Director & the Director of Risk and Safety or nominated deputy.

21. Risk Treatment/Response

The Trust will use all possible risk management measures and procedures where they are relevant: avoidance, reduction, transferring, sharing and acceptance. Risk management plans of action can lead to individual changes in both exposure and probability of risks. The current and residual levels of risk should be assessed taking into consideration combinations of these changes.

Control measures and procedures, while they may generate benefits (in terms of reduction), may be at some cost. The objective of costs against benefits is therefore central to risk-based decision making. Decisions about the need for and nature of risk control should be based on an appropriate level of cost benefit analysis and the degree of exposure to hazards. To assist in determining an appropriate level of risk tolerance the Trust considers that those risks with a high or extreme risk rating are unacceptable and will require remedial action and control.

22. Performance Monitoring

The effectiveness of this risk management strategy will be monitored regularly to ensure that the Trust is effectively maintaining managing all its risks and remains compliant with all of the minimum requirements set out by the NHSLA in the Risk Management Standards. (See appendix D for breakdown.)

23. Training Arrangements

The Learning and Development Team will be responsible for the development of a Training Needs Analysis (TNA). This will identify the training needs of the organisation and ensure that staff have access to a level of risk management training that is commensurate with their job roles and personal needs.

The process will be informed by a variety of sources including recently published legislative, guidance or professional documents, surveys, and action plans from complaints, investigations, external assessments where a training need is indicated

The analysis, as a minimum will include:

- Topics specified by NHSLA Standards TNA Minimum Data Set and any requirements arising from CQC and Information Governance Toolkit assessments
- Staff groups required to attend each type of training.
- Frequency of updates required for each type of training.

a. Training Action Plan(s)

Training plans will be developed from the Training Needs Analysis. Plans should be developed within the context of the organisations needs and should reflect national and local strategies, evidence based practise, any required competency frameworks and organisational and

workforce planning. Training needs should be summarised in a Training matrix and prospectus which should be reviewed annually by the Learning and Development Team.

b. Training Prospectus

A training prospectus will be developed by the Learning and Development Team, taking into account the training needs analysis described above. It will outline courses provided by the organisation and will include as a minimum:
-Course title, course status, target staff group, duration of course; update frequency, provider and booking arrangements.
The prospectus should be reviewed and updated annually or earlier when significant change occurs.

c. Recording Attendance at Training

The Learning and Development Team will record attendance at training and provide training reports. Reports on attendance at required training will be supplied to respective managers. These post holders are responsible for monitoring the reports and ensuring staff attend required training.

d. Following up Non-attendance at Training

By monitoring training reports, managers should recognise at an early stage when employees have failed to attend training. The Learning and Development Team follow up non-attendance by writing to the line manager.

e. Coordinating Training Records

Attendees at taught training programmes will sign a signing in sheet. Sheets will detail course title, date, venue time, instructors name and attendee's name.

All Board members, Executives and senior managers will receive relevant risk management awareness training. All members of the Quality Risk and Safety Team will trained in the use of the Trust's Risk Management Information system.

24. Communication

This Risk Management Strategy will be available to all staff through the Trust intranet.

25. Strategy review arrangements

The Strategy has a review date of 3 years post approval, but may be reviewed and amended any time if it is felt that there is national or local policy change that may warrant a revision of the strategy.

26. Key Action Areas to Reduce Risk

The Trust will focus upon a number of key action areas that are critical to the successful implementation of this strategy. These are:

- Development of Policies, Procedures and guidelines to support risk management and help mitigate the level of risk in all areas.
- Identifying risks associated with meeting the Trusts Strategic/Business objectives to allow for prompt escalation and management to mitigate risk.
- Full implementation and development of the Risk Management Information System (DATIX)
- Progressing compliance with regulators & quality minimum standards.
- Improving systems where lessons can be learned through the adoption of recognised best practice
- Improve systems so that lessons can be learned from Information Governance failures

GLOSSARY Acronyms list

NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NPSA	National Patient Safety Agency
PALS	Patient Advice and Liaison Service
RCA	Root Cause Analysis
RMIS	Risk Management Information System
SIC	Statement of Internal Control
SI	Serious Incident

Definitions list

Assurance Framework	A framework consisting of systems and processes that are able to demonstrate adequate controls are in place so that the Trust can meet its statutory responsibilities for high quality healthcare.
Control measure	A system, process or both that maintain pre-defined standards
Corporate/High Level Risks	Those risks that impact upon the Strategic/Business objectives of the organisation
Hazard	A source of potential harm or a situation with a potential to cause loss
Likelihood	Used as a qualitative description of probability or frequency
Mitigate	To make less severe
Risk	Uncertainty of outcome (whether positive opportunity or negative threat). It is the combination of the chance of an event and its consequences.
Risk Assessment	A process that involves the identification, analysis and evaluation of risks
Risk identification	The process of determining what can happen, why and how
Risk management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects
Risk register	A product used to maintain information on all the identified risks pertaining to a particular activity (project or programme).

Risk tolerance	The level at which risk is considered acceptable/unacceptable.
Risk treatment /response	Selection and implementation of appropriate options for dealing with risk
Senior Manager	Senior managers are those persons who report directly to a Director. They are generally Associate Directors or General Managers.
Strategic risk	Risk concerned with where the organisation wants to go, how it plans to get there, and how it can ensure survival.

Appendix A- Risk Management Structure and roles

Risk Management Structure	Role	Training
Trust Board, Quality Committee	• Define the Trusts risk tolerance levels. Consider strategic risks and approve the processes to manage those risks. • Ensure that public interests are protected. • Assess and monitor the efficiency and effectiveness of the Trust Risk Management system. • Holding Directors to account for effective risk management. • Seeking assurance on: • The effectiveness of the controls and actions in place to mitigate the identified risk.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.
Audit Committee	• Provide independent assurance on systems of internal control.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.
CEO	• Define Trust risk management strategy. • Have full control of Risk Management system, make strategic decisions regarding possible further implementation and development, and manage high level risks. • Ensure efficient and effective risk mitigation measures/controls. Monitoring the appropriate escalation of risk • Holding Directors to account for effective implementation of actions and controls to mitigate identified risks. • Seeking assurance on: • The effectiveness of the controls and actions in place to mitigate the identified risk.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.
Executive Board	• Monitoring the appropriate escalation of risk from respective Directorates • Holding Managers and Services to account for effective implementation of actions and controls to mitigate identified risks. • Ensure escalation of risk onto the Trust Board Assurance Framework • Seeking assurance on: • The effectiveness of the controls and actions in place to mitigate the identified risk at all levels.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.
Internal Audit	• Assess and report upon the efficiency and effectiveness of the Trusts Risk Management system and provide recommendations for improvement.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.

Risk owner	• Make tactical risk management decisions. Risk owner is responsible for and capable of risk identification, assessment and management. • Evaluate risk management strategies and measures and ensure conformance to Trust policies and procedures. In most cases risk owners are Directors of Trust services.	Risk Management Training provided for all Board Members as outlined in the Training needs analysis.
Risk Co-ordinator	• Co-ordinator of the Risk Management system and activities within a particular service Directorate. • Collection of information about the risks of a particular service and compilation of that Directorate risk register. • Responsible also for the efficiency of the controls/measures to mitigate the risks. In most cases risk coordinators are Associate Directors of both corporate and operational services. • Monitoring the appropriate escalation of risk from respective departments • Holding Managers and Services to account for effective implementation of actions and controls to mitigate identified risks. • Ensure there are controls and actions in place to mitigate the identified risk at all levels. • Ensuring that all staff have had appropriate risk management training. • Ensure identified risk is escalated to the appropriate committee for monitoring.	Risk Management Training provided for all senior embers as outlined in the Training needs analysis. Clinical Risk assessment Training is available to all clinical staff. All staff will undergo regular statutory and mandatory training which covers risk management related topics.
Line manager	• Fulfil ordinary duties taking account of existing risks and create a risk awareness climate within the service. • Undertake risk assessments of their service. Report to Risk Co-ordinator regarding existing and new risks as well as proposed changes to the measures/controls to mitigate those risks. • Line managers are the people who actually manage the risks and have authority to mitigate risk. • Monitoring the appropriate escalation of risk from respective departments • Holding Managers and Services to account for effective implementation of actions and controls to mitigate identified risks. • Ensure there are controls and actions in place to mitigate the identified risk at all levels. • Ensuring that all staff have had appropriate risk management training. • Ensure identified risk is escalated to the appropriate committee / team / meeting for monitoring. • Liaise with the appropriate department to escalate or seek advice on the management of risk ie the Health & Safety Team for Health and Safety related risks	Risk Management Training provided for all staff as outlined in the Training needs analysis. Clinical Risk assessment Training is available to all clinical staff. All staff will undergo regular statutory and mandatory training which covers risk management related topics.
All employees	• Responsible for complying with Trust Policies and Procedures, in particular those relating to incident/risk reporting, assessment and safety. To undertake risk	Clinical Risk assessment Training is available to

	assessments in their local areas. • Ensure they escalate identified risk to respective manager for further analysis and action • Seek advice from appropriate department such as the health and safety department for any Health and Safety related Risks	all clinical staff. All staff will undergo regular statutory and mandatory training which covers risk management related topics.
Director of Risk & safety	• Develop and implement Trust Risk Management Strategy. • Provide ongoing support to the Risk Management structure and ensure risk management systems are efficient and effective. • Support all the other staff in the delivery of effective risk management.	Risk Management Training provided for all Executive Board Members as outlined in the Training needs analysis.

Appendix B-Model matrix adopted from NPSA Risk Matrix

Table 1 Consequence scores : Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 414 days Increase in length of hospital stay by 4-15 days. RIDDOR/ Agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability/ death Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to multiple deaths, Multiple permanent injuries or irreversible health effects. An adverse event which significantly impacts on a large number of patients
Quality/complaints/ Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal. Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review Low performance rating Critical report Inquest/ombudsman inquiry	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss, Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**

Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

APPENDIX C –Board Level Risk Responsibility Matrix

Risks to;	CEO	Medical Director	Director of Quality (Deputy CEO)	Finance Director
Strategic objectives				
Significant Change Programmes/Projects				

Risks to;	CEO	Medical Director	Director of Quality (Deputy CEO)	Finance Director
Financial control				
Procurement				
Workforce, Recruitment, Payroll				
Information governance				
Clinical governance				
Health & Safety				
Fire Safety				
Environmental				
IM & T				
Estate/Built environment				
Corporate Governance				
Quality of clinical services				
Learning & development				
Food Safety				
Emergency preparedness				
Safeguarding				
Mental Health Act				

Note: For further guidance refer to the Trust's Scheme of Delegation.

Appendix D- Risk Strategy Monitoring Table

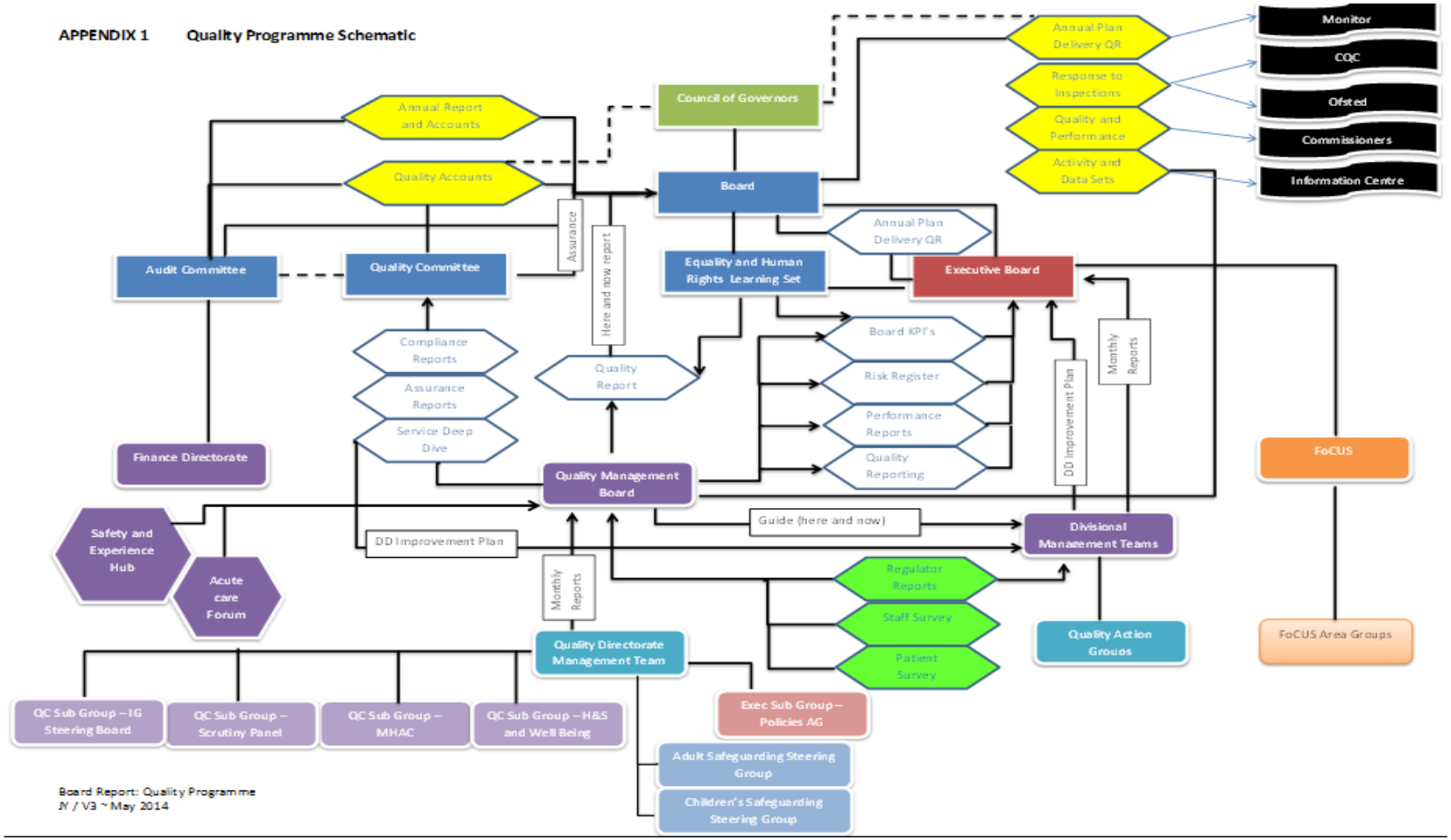
What needs Monitoring	Who will lead on this aspect of monitoring	What tool will I use to monitor/check that everything is working according to this element of the policy	How often will we need to monitor/ frequency	Who or what committee will I report the results to for information and action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and lessons shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Duties	Director of Risk & Safety	Review of Risk Register	Monthly	Quality Committee / Executive Board	Director of Risk & Safety	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders.
Organisational risk management structure	Director of Quality (Deputy CEO)	Audit	Annual	Quality Committee	Associate Director of Quality	As above

What needs Monitoring	Who will lead on this aspect of monitoring	What tool will I use to monitor/check that everything is working according to this element of the policy	How often will we need to monitor/ frequency	Who or what committee will I report the results to for information and action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and lessons shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Review of organisational risk register	Director of Risk & Safety	Minutes of Quality Committee	At every meeting	Quality Management Board, Executive Board	Director of Risk & Safety	As above
Management of risk locally	Divisional Directors	Minutes of Quality Assurance Groups	At every meeting	Quality Management Board	Associate Director of Quality	As above
Authority of all managers to manage risk	Divisional Directors	Audit /Review	Annual	Quality Management Board	Associate Director of Quality	As above
Ensuring that all board members, executives and senior managers receive relevant risk management training	Assistant CEO	Audit /Review	Annual	Quality Management Board	Associate Director of Quality	As above
Recording attendance awareness	Director of Learning & Development	Review	Monthly	Executive Board/ Quality Management Board	Director of Learning & Development	As above

What needs Monitoring	Who will lead on this aspect of monitoring	What tool will I use to monitor/check that everything is working according to this element of the policy	How often will we need to monitor/ frequency	Who or what committee will I report the results to for information and action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and lessons shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
training						
Follow-up of nonattendance	Director of Learning & Development/ Divisional Directors	Review	Ongoing (monthly)	Health, Safety & Wellbeing Committee. Quality Management Board, Quality Action Groups	Director of Learning & Development/ Divisional Directors	As above
Process of assessing all types of risk	Director of Risk & Safety	Audit /Review	Annual	Quality Management Board	Director of Risk & Safety	As above
Process for ensuring a continual, systematic approach to all risk	Director of Risk & Safety	Audit /Review	Annual	Quality Management Board	Director of Risk & Safety	As above

What needs Monitoring	Who will lead on this aspect of monitoring	What tool will I use to monitor/check that everything is working according to this element of the policy	How often will we need to monitor/ frequency	Who or what committee will I report the results to for information and action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and lessons shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
assessments is followed throughout the organisation	Director of Risk & Safety	Audit /Review	Bi-monthly	Health & Safety Committee/ Quality Committee/ Quality Management Board	Director of Risk & Safety	As above
Assignment of management responsibility for different levels of risk within the organisation	Director Quality	Audit /Review	ongoing	Quality Management Board	Director of Risk & Safety	As above

Appendix E


APPENDIX 1 Quality Programme Schematic
Annual Report and Accounts
Quality Accounts
Council of Governors
Board
Annual Plan Delivery QR
Response to Inspections
Quality and Performance
Activity and Data Sets
Monitor
CQC
Ofsted
Commissioners
Information Centre
Audit Committee
Quality Committee
Assurance
Here and now report
Equality and Human Rights Learning Set
Executive Board
Compliance Reports
Assurance Reports
Service Deep Dive
Quality Report
Board KPI's
Risk Register
Performance Reports
Quality Reporting
DD Improvement Plan
Monthly Reports
Finance Directorate
Quality Management Board
FoCUS
Safety and Experience Hub
Acute care Forum
DD Improvement Plan
Guide (here and now)
Divisional Management Teams
Monthly Reports
Regulator Reports
Staff Survey
Patient Survey
Quality Directorate Management Team
Quality Action Groups
FoCUS Area Groups
QC Sub Group – IG Steering Board
QC Sub Group – Scrutiny Panel
QC Sub Group – MHAC
QC Sub Group – H&S and Well Being
Exec Sub Group – Policies AG
Adult Safeguarding Steering Group
Children's Safeguarding Steering Group
Board Report: Quality Programme
JY / V3 ~ May 2014

Appendix E
Equality Analysis Template

The equality analysis guidance notes and template are provided to support you in meeting the requirements of the Public Sector Equality Duty which came into force on 5 April 2011. They replace previous versions of the Trust's equality impact assessment toolkit, which should no longer be used.

You should use this template to record evidence that equality analysis has been carried out *before* policy decisions take place. The form is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by equality law.

Please ensure you read the guidance notes and any available examples before attempting to complete this form. If you require further help, please contact the Equality and Human Rights Team.

1. About the policy/project/change

Title of the policy / project / change:	Risk Management Strategy
What are the intended outcomes / changes expected as a result of this policy / project / change:	Implementation of robust constant risk management procedures
Are there links with other existing policies/projects: (if yes – provide details)	Health & Safety Risk Assessment Policy Clinical Risk Management Policy

2. Decide if the policy / project / change is equality relevant

Does the policy/project involve, or have consequences for people using services, carers, employees or other people? If yes, please state the groups of people who are likely to be affected. If yes, then the policy/project is equality relevant. If no, you can skip to section 6. However the majority of Trust policies and projects are equality relevant because they affect people in some way.	It affects all groups as it deals with how risks to all group should be identified and managed

3. Gathering evidence to inform the equality analysis

What evidence have you gathered to help inform this analysis? This can include evidence from national research, surveys & reports, interviews and focus groups, policy monitoring and evaluations from pilot projects, etc. If there are gaps in the evidence available under any of the characteristics, please explain why this is the case and state what actions will be taken to close the gaps as part of the action plan. Please ensure you check Annex C of the guidance notes for sources of evidence.

The Protected Characteristics & Evidence Using the relevant available evidence - what is known, understood or assumed about each of the equality groups / protected characteristics identified below that could be relevant to this policy / project / change. Record the sources of the evidence used
The Strategy has been drafted in accordance with the Equality Act 2010, the Prevent Strategy and the NHS protect security Standards

4. Engagement and Involvement

Record the names of the people and/or groups involved in gathering evidence and/or testing the evidence against the policy / project / change. Who and how were they involved?	
Who – name of individual / group(s) represented	How have these people been involved – e.g. meeting
Mayvis Oddoye Martin Clarke Billy Hatifani	Discussion & reports provided

5. Analysis of the potential impact of the policy / project / change

Based on the evidence you have gathered; describe any actual or likely impacts that may arise as a result of the decision and whether these are likely to be positive or negative. Where actual or likely impacts are identified, you should also state what actions will be taken to promote the likelihood of positive impacts as well as minimise or mitigate against possible or likely negative impacts, i.e. what can the Trust reasonably do to actively manage the consequences of its decision / action

Eliminate discrimination, harassment and victimisation: Does the policy / project / change, help eliminate discrimination, harassment and victimisation in any way?

If yes, provide details. If no, provide reasons	
Age	The strategy does mitigate the risks associated with discriminatory behaviour as it emphasis the need for putting in place processes to eliminate and have a zero tolerance stance of abusive behaviour including that which is discriminatory in nature
Caring responsibilities	
Disability	
Gender reassignment	
Marriage & civil partnerships	
Pregnancy & maternity	
Race / ethnicity	
Religion or belief	
Sex / gender	
Sexual Orientation	

Advance equality of opportunity: Does the policy / project / change, help develop equality of opportunity in any way? This could include removing or minimising disadvantages suffered by people due to their protected characteristics, taking steps to meet the needs of people from protected groups where these are different from the needs of other people, or encouraging people from protected groups to participate in activities where their participation is disproportionately low. If yes, provide details. If no, provide reasons	
Age	Yes it will support in the advancing of equal opportunity as it will view all people equally and steps to mitigate risks and or reduce abusive behaviour will be approach without prejudice.
Caring responsibilities	
Disability	
Gender reassignment	
Pregnancy & maternity	
Race / ethnicity	
Religion or belief	
Sex / gender	
Sexual Orientation	

Promote good relations between different groups:

Does the policy / project / change, help foster good or improved relations between different groups in any way? If yes, provide details. If no, provide reasons.	
Age	It encourage corporation across different groups of people regardless of protected characteristic
Caring responsibilities	
Disability	
Gender reassignment	
Pregnancy & maternity	
Race / ethnicity	
Religion or belief	
Sex / gender	
Sexual Orientation	

What do you consider the overall impact: This strategy will have a positive impact on staff and people who use services and other key stakeholders.

6. Action Planning

Actions to be taken as a result of this analysis (add additional rows as required):	Name of person who will take this action	Date action due to be completed
Ensure monitoring as outlined through monitoring table in the strategy takes place to ensure full implementation	Billy Hatifani	

7. Authorisation

Name & job title of person completing this analysis:	Billy Hatifani
Date of completion:	21/11/2014
Name & job title of person responsible for monitoring and reporting on the implementation of the actions arising from this analysis:	Director of Risk & Safety (Deputy DoN)
Name & job title of authorised person:	Billy Hatifani

(If there are doubts about the completeness or sufficiency of this equality analysis, seek advice from the Equality and Human Rights Team or the Legal Services & Reporting Manager in the Clinical Risk & Safety Team)	
Date of authorisation:	21/11/2014

The completed template should be presented (within a paper or as a separate paper / appendix) to the appropriate committee, steering group or management team, *before* decisions are taken.

A copy should also be forwarded to the Equality & Human Rights Team.